**Child Fatality Review #08-19**
**Region 5**
**Pierce County**

This four-month-old Caucasian male died from natural causes related to pneumonia.

## Case Overview

On April 21, 2008, the deceased child's father found the infant in his crib pale, unresponsive and with vomit on his face. Medics were contacted as the father attempted CPR. Upon arrival to the home medics intubated the infant and continued CPR en route to the hospital. The infant arrived at the hospital with no pulse. There were no observable signs of trauma. The infant was then transported to Mary Bridge Children's Hospital where he died. The medical examiner found no indication of child maltreatment. Both Child Protective Services (CPS) and local law enforcement investigated the circumstances surrounding this child's death. In addition, the Pierce County Medical Examiner determined that the cause of death was related to pneumonia, and the manner of death was declared to be natural.

## Referral History

On April 10, 2008, a staff at a Women, Infants and Children nutritional program (WIC) program reported to Child Protective Services (CPS) intake that the deceased child, then four-months-old child, was not gaining enough weight. Additionally, his mother refused to feed him more often and would not follow advice from the WIC dietitian to increase his food intake. This child was born premature weighing 3 pounds 9 ounces at birth. The referrer reported this baby was starving and his mother was overwhelmed by stress and financial difficulties.

This referral was initially screened out for investigation. There was on-going contact between CPS intake, the deceased child's primary care physician, WIC and the Maternity Support Services provider. On April 22, 2008, the decision was made to screen in this referral for CPS investigation based on new information related to dietary and nutritional matters as well as a missed doctor's appointment. The child died the following day of natural causes related to pneumonia. Both CPS and law enforcement investigated and neither found evidence of child maltreatment leading to this child's death. The CPS investigation was closed as unfounded. No services were offered by the department to this family as the infant died prior to any contact by social workers.

## Issues and Recommendations

**Issue:** Numerous community and medical providers were involved with this family prior to any reported concerns to CPS on April 10, 2008. A staff person with Women, Infants

and Children nutritional program (WIC) reported concerns regarding feeding, nutritional and dietary issues, and inadequate weight gain of a four-month-old infant. A day prior to making the referral to CPS the WIC worker had faxed the client's High Risk Care Plan to the child's doctor. The infant's growth charts were not transmitted. Following best practice, collateral contacts were made by the CPS intake worker with the primary care physician (PCP) office and the Maternity Support Services/Infant Care Management (MSS/ICM) provider. The concerns reported by the WIC staff person were not confirmed by the assessments of these other service providers.

The fact that different agencies working with the same parent and infant had differing perceptions of the child's health status made the screening decision difficult. The initial screening decision was to take the report as information only (sent to Early Intervention Program/Public Health Department) while the intake worker continued making contact with WIC and the MSS/ICM provider. On numerous occasions the information received at intake was reviewed at the supervisor level, and on April 21, 2008 the decision was made to accept the report for investigation based on new information related to dietary and nutritional matters as well as a missed (re-scheduled) doctor's appointment.

Based upon a review of records, including those from medical and community service providers, as well as on interviews conducted during the review, the panel concluded that the initial screen-out decision on April 11, 2008 appeared reasonable given the information provided at that time which included conflicting opinions about the infants health status and the mother's ability to care for the child. Overall the efforts made by the intake worker were assessed to be of excellent quality by the review participants, noting specifically the worker's documentation and her persistence in attempting to gather additional information from a variety of sources even days after the screen-out decision. The panel concluded that the decision made ten days later to screen-in the report based on new information was reasonable. As noted, the child died the following morning from pneumonia, and there was no post-mortem evidence of malnutrition or child maltreatment.

**Recommendation:** None

Actions Taken: The intake worker and intake supervisor were present during the review and received feedback regarding the intake decisions made.

**Issue:** Several practice issues surfaced during the child fatality review which provided an opportunity for discussions about improving practice for Region 5 intake as well as for the participating community providers in their collaborative role with CA.

Information from the dietician came second-hand to CPS intake through the WIC worker and a WIC supervisor, both of whom were limited in speaking to specific dietary issues and to expectations for weight gain for premature infants. The intake worker might have

been more insistent with the referent in asking that the dietician contact intake directly. The delay in getting concrete statements from the dietician regarding insufficient weight gain by the infant as opposed to generalized concerns from second-hand sources might have been avoided.

While awaiting follow-up information from WIC, the CPS intake worker might have made use of medical consultation available from the CA Region 5 Child Abuse Medical Consultant.

During the fatality review questions were raised as to the reasonableness of requesting a law enforcement welfare check on a child who allegedly might be failing to thrive. The welfare check was conducted, apparently by an officer with some self-reported experience with premature infants, and he reported no concerns regarding the home environment, the caretakers, or the appearance of the baby. While child welfare check requests to law enforcement are commonly made by CA intake units across the state, such are usually done without knowledge of what training the responding officer has had regarding child maltreatment, child development, and/or child safety.

**Recommendation:** It is outside of the role of the review panel to make recommendations regarding practice improvements for agencies outside of Children's Administration. However, CA should continue to offer training and cross-training opportunities with private, community, and government agencies.

Action Taken: The Region 5 Child Abuse Medical Consultant recently conducted an in-service training with the local WIC program. Additionally, following this child fatality review, the MSS/ICM provider and WIC provider agreed to begin working on plans for a cross-training between their respective agencies.

Action Taken: The intake worker and intake supervisor were present during the child fatality review and received feedback suggestions for improving practice. The intake worker acknowledged awareness of access to statewide child abuse Medical Consultant Network at the time of the intake. In March 2008, a month prior to this child's fatality, intake workers from Region 5 (Pierce and Kitsap Counties) met to discuss a variety of intake-related issues. At that time medical consultation resources available to intake workers were discussed, including contact information for the three CA child abuse medical consultants then servicing Western Washington. While the focus of the regional intake meeting was on physical injuries and medication/poisoning issues regarding infants and young children, additional topics for future intake training were discussed at that quarterly meeting.

Action Taken: Speakers from the local Child Advocacy Center/Child Abuse Intervention Department (CAC/CAID) were scheduled to present to the Region 5 Intake Units on October 20, 2008. Additional cross-training with Mary Bridge Children's Hospital

(MBCH) is in the planning stage, with the Regional Child Abuse Medical Consultant committing to provide training for regional intake staff on special needs infants and on newborn care, with a focus on health and safety. As part of the training plan, regional intake staff will visit the MBCH Neonatal Intensive Care Unit (NICU) in pairs over a period of several months.